

A GUIDE TO THE LAW ON NHS CONTINUING CARE AND NHS FUNDED NURSING CARE

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1. What is NHS Continuing Healthcare (“CHC”)?

1.1 This chapter is a general guide to the law and practice around NHS Continuing Care (referred to as “CHC”). CHC is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and who have complex ongoing healthcare needs to such an extent that the patient can be described as having a “primary health need” (referred to as “CHC”)¹. The Department of Health has recently published a helpful summary about CHC in the form of a leaflet² which is a good start to explaining the complexities of a service that is widely misunderstood.

1.2 The present version of the **National Framework on NHS Continuing Care**³ defines NHS Continuing Care as follows:

“‘NHS continuing healthcare’ means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a ‘primary health need’ as set out in this guidance. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery”

1.3 CHC is thus a package of health and social care services (and possibly accommodation if that is part of the patient’s needs) to meet a patient’s reasonable requirements for such services, all of which is funded by the NHS. This is shown at paragraph 25 of the National Framework which provides:

¹ See <http://www.nhs.uk/chq/Pages/2392.aspx>.

² See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193700/NHS_CHC_Public_Information_Leaflet_Final.pdf

³ The present version was published in 2012. There were previous versions in 2007 and 2009. The full document is available on the Department of Health website.

“Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual’s assessed needs – including accommodation, if that is part of the overall need”

1.4 A decision that the patient is eligible for NHS CHC means, in practice, that the whole of the care package for that patient will be funded by the NHS as opposed to the costs being shared between the NHS and social services authorities (i.e. the local authority). This means that none of the services for a CHC patient are designated as being means tested services under the social care system but are provided by the NHS, i.e. generally free of charge. Frequently CHC patients are provided with care in private care homes as opposed to being provided with care directly by staff employed by NHS bodies because Clinical Commissioning Groups contract with private care homes to provide the required services (as they are permitted to do under section 10 of the NHS Act⁴).

2 A brief history of government policy concerning CHC.

2.1 The concept of NHS Continuing Care emerged out of concerns in the 1980s and early 1990s that patients with complex conditions were being treated outside NHS hospital where the same patients would previously have received this care within an NHS hospital. Patients who receive their health and social care in an NHS hospital are provided with their medicines, food, accommodation and social care free of charge. Although this is often taken for granted, the provision of food, accommodation and social care is the provision of “non-medical” support to hospital patients, funded by the NHS. Thus, the provision of food, accommodation and social care funded by the NHS comes as part of an overall “NHS hospital” package of care. However, the NHS does not generally provide “non-medical” support for patients outside an NHS hospital environment. Where such services are needed by patients, they are either paid for by patients themselves or are community care services which are the responsibility of a local authority under the Care Act 2014. Community care services are subject to means testing and, for those with means, to charges.

2.2 When the NHS was created a large number of individuals were provided with long term care in NHS hospitals. There were “back-wards” in NHS hospitals which provided long term care to

the elderly. Although it is dangerous to generalise, these “patients” were often the frail elderly and often had minimal acute medical input, patients with learning difficulties who mainly needed social care and patients with long term conditions that were managed within a hospital environment. In the early 1950s the NHS maintained 32,000 TB beds and had a considerable estate of “mental health” institutions providing care for those with learning difficulties, many of whom would not now be considered to have a mental health disorder. Most patients with learning difficulties had social care needs but far fewer had physical or mental health needs. There is an excellent history of the changes to the NHS and how these long term beds were phased out in the King’s Fund interim report *“A new settlement for health and social care”*⁵. This explains how, over an extended period, starting in the 1960s, these long term beds were phased out, with many former long stay patients being provided with social care services in place of an NHS bed (often called “care in the community”).

- 2.3 There are 2 crucial differences between NHS services and community care services. First, as far as the service user/patient is concerned, NHS services are largely funded out of government money (i.e. provided by taxpayers) and thus provided free of charge to the individual patient. In contrast, community care services have always been subject to a means tested contribution being paid by the service user⁶. Secondly, NHS services are funded by NHS bodies exercising target legal duties. In contrast, community care services are provided by local social services authorities (unitary Councils or County Councils) under duties imposed by the Care Act 2014. These are not target duties but are duties owed by local authorities directly to individual service users. Hence, one effect of changing medical patterns of care which moved medical treatment for patients with complex conditions out of the hospital environment was to transfer responsibility for the duty to provide accommodation and social care away from the NHS and, at least in a majority of cases, to a local authority. This change also changed the services from being “free at the point of use” to being a service where the user had to pay, subject to a means test. But, that statutory change also resulted in the costs of provision of these services being transferred from the NHS (i.e. nationally managed state funds) to either patients or local authorities.

⁴ The National Health Service Act 2006

⁵ See <http://www.kingsfund.org.uk/press/press-releases/independent-commission-calls-new-settlement-health-and-social-care>

- 2.4 The first relevant Guidance that attempted to describe the dividing line between statutory health and social care responsibilities was Health Service Guidance (92)50 which was issued when the National Health Service and Community Care Act 1990 came into force in April 2003. The 1990 Act imposed a statutory duty on social services authorities to conduct assessments of the needs of service users who required community care services. The coming into force of the 1990 Act was accompanied by a guideline document, HSG(92)50, issued by the NHS Management Executive to district health authorities called "*Local authority contracts for residential and nursing home care: NHS related aspects*". It provided:

"This guidance sets out district health authority and local authority responsibilities, from April 1993, for funding community health services for residents of residential care and nursing homes who have been placed in those homes by local authorities."

- 2.5 The guidance proposed a distinction between "*specialist*" nursing services, which would continue to be provided by the NHS, and "*general nursing care*", which the guidance proposed should be for the local authority to fund. The Guidance said:

"Full implementation of the White Paper 'Caring for People' will mean that local authorities will have responsibilities for purchasing nursing home care for the great majority of people who need it and who require to be publicly supported. When, after April 1993, a local authority places a person in a nursing home after joint health authority/local authority assessment, the local authority is responsible for purchasing services to meet the general nursing care needs of that person, including the cost of incontinence services (e.g. laundry) and those incontinence and nursing supplies which are not available on NHS prescription. Health authorities will be responsible for purchasing, within the resources available and in line with their priorities, physiotherapy, chiropody and speech and language therapy, with the appropriate equipment, and the provision of specialist nursing advice, e.g. continence advice and stoma care, for those people placed in nursing homes by local authorities with the consent of a district health authority. Health authorities can opt to purchase these services through directly managed units, NHS trusts, or other providers including the nursing home concerned. Health authorities continue to have the power to enter into a

⁶ This distinction goes back to the National Assistance Act 1948 and the National Health Act 1946, both of which emerged out of the 1941 Beveridge Report.

contractual arrangement with a nursing home where a patient's need is primarily for health care. Such placements must be fully funded by the health authority"

- 2.6 The Guidance thus suggested that the NHS would continue to have a power (but possibly not a duty) to purchase a nursing place for an NHS patient where the "*patient's need is primarily for health care*". However, the guidance gave no indication as to how the NHS was supposed to determine whether a patient's needs were primarily for healthcare as opposed to having a primary need for social care. It was also unclear from this Guidance whether the NHS would have a power or only a duty to provide a nursing home place (and hence a package including accommodation and social care services) for a patient whose needs were primarily for healthcare.
- 2.7 The practical consequence of this policy was that, once patients with complex conditions moved out of the NHS hospital environment, accommodation, social care and support was generally funded by patients themselves or by local authorities. Health authorities limited themselves to providing "specialist" health services, but looked to the local authority to provide accommodation and social care services pursuant to their community care obligations.
- 2.8 Further Guidance was issued in 1995 called "*Continuing Care: NHS and Local Councils' responsibilities*". The 1995 guidance included some general principles which attempted to define where the line lay between the duties of local authorities and those of NHS bodies. It said the NHS was responsible for arranging and funding in-patient continuing care in a hospital or nursing home, on a short or long term basis, for people:
- a) where the complexity or intensity of their medical, nursing care or other care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team;
 - b) who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or

- c) who have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.

2.9 The Department issued supplementary guidance in February 1996, which referred to the danger of eligibility criteria being over-restrictive. It specifically mentioned the risk of over-relying on the needs of a patient for specialist medical opinion when determining eligibility for continuing NHS funded care. It said that there would be a limited number of cases where the complexity or intensity of nursing or other clinical needs might mean that a patient was eligible for continuing care even though that patient no longer required medical supervision.

2.10 The next step on the tortuous history of the development of CHC was the seminal case of R v. North and East Devon Health Authority ex-parte Pamela Coughlan in July 1999. The Court of Appeal was required to consider whether the health authority had acted lawfully in seeking to close Mardon House and to transfer care responsibilities for the residents to the local authority. At first instance, Hidden J explained that the residents needed nursing services and that, in his view, these could only be provided by an NHS body. He said the provision of both general and specialist nursing services were "'health care' and can never be 'social care'". His view was that the health authority was wrong because:

"both general and specialist nursing care remain the *sole responsibility* of the health authorities"

2.11 The Health Authority appealed and the Court of Appeal had to decide where the line was to be drawn between health and social care services. The Court of Appeal did not see the divide in such clear terms as the Judge at first instance. The conclusions of the Court of Appeal are worth setting out in full as follows:

"(a) The Secretary of State can exclude some nursing services from the services provided by the NHS. Such services can then be provided as a social or care service rather than as a health service.

(b) The nursing services which can be so provided as part of the care services are limited to those which can legitimately be regarded as being provided in connection with accommodation which is being provided to the classes of persons referred to in

section 21 of the 1948 Act who are in need of care and attention; in other words as part of a social services care package.

(c) The fact that the nursing services are to be provided as part of social services care and will have to be paid for by the person concerned, unless that person's resources mean that he or she will be exempt from having to pay for those services, does not prohibit the Secretary of State from deciding not to provide those services. The nursing services are part of the social services and are subject to the same regime for payment as other social services. Mr Gordon submitted that this is unfair. He pointed out that if a person receives comparable nursing care in a hospital or in a community setting, such as his or her home, it is free. The Royal Commission on Long Term Care, in its report, "With Respect to Old Age" (Cm 4192-I) (March 233 1999), chapter 6, pp 62 et seq, not surprisingly agrees with this assessment and makes recommendations to improve the situation. However, as long as the nursing care services are capable of being properly classified as part of the social services responsibilities, then, under the present legislation, that unfairness is part of the statutory scheme.

(d) The fact that some nursing services can be properly regarded as part of social services care, to be provided by the local authority, does not mean that all nursing services provided to those in the care of the local authority can be treated in this way. The scale and type of nursing required in an individual case may mean that it would not be appropriate to regard all or part of the nursing as being part of "the package of care" which can be provided by a local authority. There can be no precise legal line drawn between those nursing services which are and those which are not capable of being treated as included in such a package of care services.

(e) The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide to the category of persons to whom section 21 of the 1948 Act refers and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide, then they can be provided under section 21. It will be appreciated that the first part of the test is focusing on the overall quantity of the services and the second part on the quality of the services provided.

(f) The fact that care services are provided on a means tested contribution basis does not prevent the Secretary of State declining to provide the nursing part of those

services on the NHS. However, he can only decline if he has formed a judgment which is tenable and consistent with his long-term general duty to continue to promote a comprehensive free health service that it is not necessary to provide the services. He cannot decline simply because social services will fill the gap”

2.12 This Court of Appeal judgment appears to be the origin of the “incidental or ancillary” test concerning residential accommodation which defines the type of care placements that can properly be classified as being social care. This test continues to be part of the process of assessing eligibility to CHC today. It seems that this part of the judgment was, in effect, the Court of Appeal “legislating”, although in part it was building on the approach taken in the 1995 Guidance. However, this part of the *Coughlan* case was primarily about whether a local authority was lawfully obliged to provide nursing services. It was not (at least at this stage of the argument) a case about whether the NHS was under a duty to fund accommodation and social care services. It thus left open the possibility of a gap between health and social care provision.

2.13 The next significant step was section 49 of the Health and Social Care Act 2001 which effectively prevented local authorities from employing registered nurses as part of the package of care provided at local authority care homes or funding care to be provided by nurses at homes run in the private sector. This legislation was, in part, a government response to the Royal Commission on Long Term Care chaired by Sir Stewart Sutherland (“the Sutherland Report”). The Sutherland Report had recommended that personal care for elderly people in need should be made available to everyone, subject to a needs assessment. It thus recommended that personal care for elderly people should be paid for from general taxation and that, for others, it should be subject to co-payment arrangements according to means. The then government were not prepared to accept the recommendations (or pay the cost of this bold recommendation) but as a compromise it enacted section 49 of the 2001 Act. This provided:

“(1) Nothing in the enactments relating to the provision of community care services shall authorise or require a local authority, in or in connection with the provision of any such services, to—

(a) provide for any person, or

(b) arrange for any person to be provided with,

nursing care by a registered nurse.

(2) In this section “nursing care by a registered nurse” means any services provided by a registered nurse and involving—

(a) the provision of care, or

(b) the planning, supervision or delegation of the provision of care,

other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.

2.14 The broad effect of section 49 was thus to prevent local authorities from having either the legal power or legal duty to employ or pay for nursing services as part of their community care obligations. The idea was to ensure that, where the services of a nurse were required by a patient outside of a hospital environment, those services should be funded by the NHS and not by a local authority.

2.15 Following the *Coughlan* judgement the Department of Health released some fairly unhelpful Guidance “*Continuing Care: NHS and Local Council's Responsibilities HSC 2001/015*”. This Guidance introduced a distinction between “continuing care” and “Continuing NHS health care” for the first time. It defined continuing care as follows:

‘Continuing care’ (or ‘long term care’) is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, from an NHS hospital, to a nursing home or residential home, and people's own homes”

In contrast it defined “Continuing NHS Health care” as follows:

“Continuing NHS health care’ describes a package of care arranged and funded solely by the NHS. It does not include the provision by local councils of any social services”

2.16 The Guidance then recommended that local health authorities set their own eligibility criteria to determine which patients were and were not entitled to Continuing NHS Health care (i.e. a package of health and community care services care funded exclusively by the NHS). Annex C gave some guidance about what should be contained within local NHS policies. It said:

“1. The eligibility criteria or application of rigorous time limits for the availability of services by a health authority should not require a local council to provide services beyond those they can provide under section 21 of the National Assistance Act (see point 20 of the guidance for the definition of nursing care used in the Coughlan judgement).

2. The nature or complexity or intensity or unpredictability of the individual’s health care needs (and any combination of these needs) requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

3. The individual’s needs require the routine use of specialist health care equipment under supervision of NHS staff.

4. The individual has a rapidly deteriorating or unstable medical, physical or mental health condition and requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

5. The individual is in the final stages of a terminal illness and is likely to die in the near future.

6. A need for care or supervision from a registered nurse and/or a GP is not, by itself, sufficient reason to receive continuing NHS health care.

7. The location of care should not be the sole or main determinant of eligibility. Continuing NHS health care may be provided in an NHS hospital, a nursing home, hospice or the individual’s own home.

Guidance on free nursing care will include more details on determining registered nurse input to services in a nursing home, where the care package does not meet continuing NHS health care eligibility criteria”

2.17 This Guidance demonstrated the tensions in government which have always been present in CHC policy. There are 2 primary sets of tensions. First, there are tensions between health and social care organisations. A patient with serious disabilities represents a long-term resource commitment for the state. Thus working out which side of the NHS/social care line such a patient falls is important because both NHS and local budgets have been under immense pressure and will remain under pressure for the foreseeable future. Secondly there are tensions between patients (and their families) and the NHS. Patients naturally want to fall under NHS Continuing Care because this will result in the patient getting social care and accommodation which is free at the point of use. The practical consequence of “going into [social] care” is that many family homes have to be sold to pay care fees. Thus the entirely understandable aspiration of both the patient and their relatives that the home should be an asset to be passed to the next generation is thwarted. Whilst this is an entirely legitimate perspective, some of the mechanisms used by families to avoid the state getting their hands on the home may have less legitimacy. From the NHS perspective, the expression “where there’s a will, there’s a relative” has come to the mind of many NHS officials struggling to define the boundary and trying to explain to an insistent relative why their elderly mother or father is not entitled to CHC. Those two sets of tensions – the NHS/LA tension and the NHS/patient and family tension – run through CHC policy like the word Brighton runs through a stick of seaside rock. There are always present, albeit often just below the surface.

2.18 In 2003 the Parliamentary and Health Service Ombudsman issued a special report *NHS funding for long term care* (February 2003, HC 399) which criticised both central government and individual NHS bodies in relation to their approach to eligibility for CHC, and upheld a large number of specific complaints from members of the public where a patient had been denied free NHS and social care. The Ombudsman reported on the 2001 Guidance in the following unflattering terms:

"A pattern is emerging from the complaints I have seen of NHS bodies struggling, and sometimes failing, to conform to the law and central guidance on this issue, resulting in actual or potential injustice arising to frail elderly people and their relatives (paragraph 1).

I do not underestimate the difficulty of setting fair, comprehensive and easily comprehensible criteria. The criteria have to be applied to people of all ages, with a

wide range of physical, psychological and other difficulties. There are no obvious, simple, objective criteria that can be used. But that is all the more reason for the Department to take a strong lead in the matter: developing a very clear, well-defined national framework. One might have hoped that the comments made in the *Coughlan* case would have prompted the Department to tackle this issue. However, efforts since then seem to have focused mainly on policy about free nursing care. Authorities were left to take their own legal advice about their obligations to provide continuing NHS health care in the light of the *Coughlan* judgment. I have seen some of the advice provided, which was, perhaps inevitably, quite defensive in nature. The long awaited further guidance in June 2001 [HSC 2001/015] gives no clearer definition than previously of when continuing NHS health care should be provided: if anything it is weaker, since it simply lists factors authorities should 'bear in mind' and details to which they should 'pay attention' without saying how they should be taken into account. I have criticised some Authorities for having criteria which were out of line with previous guidance: except in extreme cases I fear I would find it even harder now to judge whether criteria were out of line with current guidance. Such an opaque system cannot be fair. (paragraph 31)"

- 2.19 There are 2 legitimate criticisms of the PHSO report. First, it criticised variations between the policies adopted by different health authorities. That is a misguided criticism because the NHS has always been set up a national service with local decision makers. Whenever there are local decision makers, there will be differences between the decisions that are made. Hence differences between services being made available in different areas is an inevitable consequence of the decision making system, not necessarily evidence that the system is failing. Secondly, it is arguable that the report only considered the perspective of prospective CHC patients and their families. It gave insufficient weight to the needs of other patients who were also seeking funding for NHS treatment out of the same limited budget. However the NHS was probably too timid to point out these errors and largely adopted a “*mea culpa*” approach.
- 2.20 The 2001 Guidance was also subsequently the subject of some pointed criticism by Mr Justice Charles in *R (on the application of Grogan) v Bexley NHS Care Trust & Ors* [2006] EWHC 44 (Admin). However the Judge in that case importantly noted at §37:

“.. the divide between the duties relating to the provision of health services and social services is not between two duties that are enforceable by individuals. This is because

the duties of the local authority are so enforceable but the relevant duties of the [Secretary of State] in respect of the NHS are "target duties"

The Judge also said at §39:

"I accept as submitted on behalf of the [Secretary of State] that the extent of her duties to provide health services is governed by the health legislation and not by the limits of the duties of local authorities. Thus I accept that there is potential for a gap between what the [Secretary of State] (through the relevant health bodies) provides, or is under a duty to provide, as part of the NHS, and "health services" that could lawfully be supplied by local authorities"

The Judge complained that the 2001 Department of Health Guidance was "*far from being as clear as it might have been*" and concluded that it was partially to blame for the failure of local NHS bodies to adopt a consistent approach to eligibility for CHC. However, one significant feature of the *Grogan* case was that the local authority were not parties to the action and hence not represented at court. Thus, the court only had the perspectives of the patient, the Secretary of State and the NHS, but was not assisted by the perspective of the local authority.

- 2.21 The adoption of different eligibility criteria by different health authorities and the newly emerging local commissioners, known as "primary care trusts" ("PCTs"), led to a plethora of complaints about a "post code lottery" around the entitlement of individual patients to CHC. Complaints about a postcode lottery are a standard of any debate on NHS services. Critics of decisions often affirm the benefits of "local decision making", assuming a local decision will be in their favour, but equally complain about decisions varying between localities when they go against them. A "postcode lottery" is, of course, the inevitable result of local decision making. However, the perceived unfairness of different CHC eligibility policies in different areas led the Department of Health to require CHC eligibility criteria to be set by Strategic Health Authorities ("SHAs") from 1 April 2004.
- 2.22 PCTs remained as the statutory decision makers to decide which patients were eligible for CHC but, in making this decision after 1 April 2004, PCTs were required to use the SHA eligibility criteria to determine eligibility for NHS Continuing Care. This change was aimed at delivering a greater level of consistent approach over the area of the SHA. At this stage, there

were 10 (later 9) SHAs covering the whole of England. However, there were still elements of post-code lottery in this system because the interpretation of the SHA criteria differed between different PCTs within the SHA area and, even if a patient was eligible, the package of care that an eligible patient received was determined by the policies of individual PCTs.

- 2.23 The 2001 Guidance introduced a further stage for patients, namely the SHA Review Panel. These panels were commonly referred to as “Appeal Panels” but this was not strictly correct because they only made recommendations back to the PCTs, and could not uphold make the decision to uphold an appeal. However, few if any of the recommendations were not accepted by PCTs.
- 2.24 The adoption of SHA eligibility criteria and SHA appeal panels did not lead to a completely uniform approach across the country and hence complaints continued. The government responded by introducing national CHC criteria covering the whole of England. These were adopted first in the first National Framework for NHS Continuing Healthcare which was published in October 2007. The National Framework was updated in 2009 and was further updated in 2012.
- 2.25 The present position is thus that a person’s eligibility for CHC is determined by applying rules in part 6 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the 2012 Regulations”) which, in turn, follows the decision making process set out in the 2012 version of the National Framework. The details of the eligibility decision making process are explained below. However, the package of services that an eligible patient receives is still governed by the policies of the local NHS commissioners, who are now the local Clinical Commissioning Groups.

3 The legal basis for the provision of NHS Continuing Care.

- 3.1 The 1995 Guidance grappled with the problem as to when the NHS should provide a comprehensive package of health and social care services for a seriously ill patient, which was free at the point of use but was delivered outside of a hospital environment. That conundrum has remained the central issue for subsequent policy makers in this area. From a

legal perspective, section 3 of the NHS Act 2006 requires clinical commissioning groups, who are the statutory successors of PCTs, to make arrangements to provide the following services:

“(1) “A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility:

- (a) hospital accommodation;
- (b) other accommodation for the purpose of any service provided under this Act;
- (c) medical, dental, nursing and ambulance services;
- (d) such other facilities for the care of expectant and nursing mothers and young children as the group considers are appropriate as part of the health service;
- (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service;
- (f) such other services as are required for the diagnosis and treatment of illness”

3.2 NHS Continuing Healthcare (“CHC”) involves the provision of a “package” of care and support services to meet the needs of someone who has a primary healthcare need. This can include medical care (i.e. the services of medical professionals plus drugs and other medical inventions). However, it can also include accommodation and social care in addition to medical care. The legal basis for the provision of such services is a combination of section 3(1)(c) (for medical and nursing services), section 3(1)(b) (for accommodation) and section 3(1)(e) (for social care and other services). In *R (Whapples) v Birmingham Crosscity Clinical Commissioning & Anor* [2015] EWCA Civ 435 the Court of Appeal found that the power to create the National Framework was contained in section 2 of the NHS Act.

- 3.3 The obligation to provide accommodation to CHC patients, when this is part of their overall needs, probably arises under section 3(1)(b) although a clear view on this is somewhat difficult as a result of the judgments in *Whapples* which specifically left the matter open. It appears reasonably clear that the duty to provide accommodation to a CHC patient outside a hospital arises when the patient has a “reasonable requirement” for accommodation for the purpose of any service provided under the NHS Act. That raises the slightly difficult question as the meaning of the term “hospital” in the NHS Act. The word “hospital” is widely defined in section 275 of the NHS Act to include “any institution for the reception and treatment of persons suffering from illness”. A care home can amount to a “hospital” where the resident requires and is provided with nursing services: see *Minister of Health v General Committee of the Royal Midland Counties Home for Incurables at Leamington Spa* [1954] 1 Ch 530, *Chief Adjudication Officer v White* (reported as R(IS) 18/94) and *Botchett v Chief Adjudication Officer* (reported as R(IS) 10/96. See also *R (DLA 2/06)* which explains the legislative history in some detail.
- 3.4 However, the obligation to provide accommodation will rarely, if ever, result in the NHS having a duty to provide “ordinary accommodation” to a patient outside of a care home environment. In *Whapples* the Court of Appeal said:
- “Read as a whole, the National Framework does not, in circumstances where a patient is receiving NHS continuing healthcare in his own home, generally contemplate that the NHS will be responsible for defraying the costs of that accommodation”
- 3.5 However, that case made it clear that, where a person needs accommodation which is different from the accommodation in which they are presently living in order to deliver health and social care services, a local authority may well have a duty to provide suitable accommodation to such a person under its community care powers. These powers were under section 21 of the National Assistance Act 1948 in *Whapples* and are now under the Care Act 2014 after 1 April 2015.
- 3.6 The extent of the NHS’s obligation to provide “other services” under section 3(1)(e) is subject to the additional qualification that they are only such services as the CCG considers to be

“appropriate as part of the health service”. That clearly gives the CCG a wide discretion to determine the circumstances in which CHC services should and should not be provided to NHS patients. However, in exercising that discretion, the CCG must follow the guidelines set out in the National Framework unless it has a good reason to depart from the guidance.

4 Who qualifies for CHC?

4.1 From October 1st 2007, a National Framework is required to be used by local NHS decision makers to determine eligibility. The National Framework has been updated from time to time and the present version dates from November 2012⁷. The rules on CHC eligibility are now contained in the 2012 Regulations. Part 6 of the 2012 Regulations⁸ sets out the tests to be applied by each CCG to determine whether a patient is eligible for CHC.

4.2 The CCG or NHS England decision making process to determine whether a patient is eligible for CHC ought to be completed and a decision made and communicated to the patient within a maximum of 28 days. Paragraph 95 of the National Framework sets out the timescales as follows:

“The time that elapses between the Checklist (or, where no Checklist is used, other notification of potential eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. In acute services, it may be appropriate for the process to take significantly less than 28 days if an individual is otherwise ready for discharge. The CCG can help manage this process by ensuring that potential NHS continuing healthcare eligibility is actively considered as a central part of the discharge planning process, and also by considering whether it would be appropriate to provide interim or other NHS-funded services, as set out in paragraph 65 above”

4.3 Regulation 20 transposes the definitions of “NHS continuing care” into statute for the first time. The definition is the same as in the National Framework, namely:

⁷ See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

⁸ The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 SI 2996/2012 as amended by a series of subsequent amendment Regulations.

“NHS Continuing Healthcare” means a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness”

The word “care” is not defined in the Regulations or in the NHS Act and so the meaning of the services that can be provided as part of a package of “care” must be taken from the Guidance.

4.4 Regulation 21(1) provides:

“A relevant body must take reasonable steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out in respect of a person for which that body has responsibility in all cases where it appears to that body that—

(a) there may be a need for such care; or

(b) an individual who is receiving NHS Continuing Healthcare may no longer be eligible for such care”

4.5 The 2012 Regulations thus impose a statutory duty on the CCG to carry out an assessment if the CCG is aware of the existence of the individual and has information that “may” suggest a need for CHC or a variation in the care services, the CCG is under a specific legal duty to carry out a CHC assessment. The information can come from any source including a local authority, provided there is enough information to lead the CCG to believe that the patient may qualify for CHC. The duty to carry out a CHC assessment can thus arise whether there is a request by the patient or not. The wording of the duty is substantially the same as the duty on a local authority to carry out an assessment of an individual’s entitlement to community care services under section 9 of the Care Act 2014 (formerly 47 of the NHS and Community Care Act 1990). The case law suggests that there is a low threshold before the duty to carry out an assessment arises (see *R (Pinfold) v Bristol Council*). All that is needed to trigger a duty to carry out an assessment is for the CCG to have sufficient information that a patient “may” be eligible for CHC.

- 4.6 The duty in the 2012 Regulations to carry out a CHC assessment can arise where a patient is being discharged from hospital if, at the point of discharge, the CCG believes that the patient may qualify for CHC. There is also a duty on the CCG and a Hospital Trust to consider whether a patient qualifies for CHC when discharging a patient from hospital if there is a delayed discharge and the Trust or CCG want to use the mechanism of the Community Care (Delayed Discharges) Act 2003 to charge social services for the costs of the delayed discharge. Before any notices can be served under that Act the Delayed Discharges (Continuing Care) Directions 2013⁹ (“the Delayed Discharges Directions”) require the Trust or CCG to take reasonable steps to ensure that an assessment for CHC is carried out in all cases where it appears that the patient may have a need for such care.
- 4.7 There is also a duty to carry out an assessment if a patient “may no longer be eligible for such care”. Hence if a CCG has information that suggests that a CHC eligible patient is no longer eligible for CHC, the CCG has a duty to carry out an assessment to determine the true position.

The CHC Checklist as an initial screening tool.

- 4.8 If the CCG has a legal duty to conduct a CHC assessment, the first step is often to use the CHC Checklist as an initial screening tool to screen out patients who are clearly not eligible for CHC (although there is no absolute legal duty to do so). Regulation 21(4) provides:

“If a relevant body wishes to use an initial screening process to decide whether to undertake an assessment of a person’s eligibility for NHS Continuing Healthcare it must—

(a) complete and use the NHS Continuing Healthcare Checklist issued by the Secretary of State and dated 28th November 2012(11) to inform that decision;

(b) inform that person (or someone lawfully acting on that person’s behalf) in writing of the decision as to whether to carry out an assessment of that person’s eligibility for NHS Continuing Healthcare; and

⁹ See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254680/Delayed_discharges_directions.pdf

(c) make a record of that decision”

4.9 The National Framework suggests that the Checklist procedure should be used as a first step in most cases. The procedure can be conducted by a nurse, doctor, social worker or other qualified healthcare professional. The National Framework states that:

“.. the tool could form part of the discharge pathway from hospital, a GP or a nurse could use it in an individual’s home, and Social Services workers could use it when carrying out a Community Care assessment. This list is not exhaustive, and in some cases it may be appropriate for more than one person to be involved”

The purpose of the checklist is to help practitioners identify people who need a full assessment for NHS continuing healthcare and those who do not have sufficient needs to justify a full assessment. The form that should be completed goes through the care domains set out in the full assessment process and is attached to the Checklist document. Completion of the Checklist fulfils the duty in Regulation 21(4) to make a record of the decision. If a decision is made that a person is not CHC eligible after following the Checklist procedure, that is a sound basis for a CCG concluding that the person is not eligible for CHC.

4.10 The CHC Checklist requires the multi-disciplinary team to assess whether the individual meets or exceeds the described need across 11 Care Domains (Column A) or is Borderline (Column B). A full consideration of eligibility is required if there are:

- two or more ticks in column A.
- five or more ticks in column B; or one tick in A and four in B.
- one tick in column A in one of the boxes marked with an asterisk (i.e., the domains which carry a priority level in the Decision Support Tool), with any number of ticks in the other two columns.

4.11 There may be special circumstances where a full consideration for NHS Continuing Healthcare is necessary even though the individual does not appear to meet the indicated threshold. If the patient does not pass the above tests then the CCG can be confident that the patient does not qualify for fully funded CHC. However, getting through the initial screening tool

does not mean that a patient will qualify for fully funded CHC. There are many patients who will get through the initial screening but will not be entitled to fully funded CHC.

- 4.12 The form to be completed as part of the initial screening tool contains a section where the healthcare worker who completes the forms records their reasons for or against a full assessment. Completing the form with reasons is a legal requirement under the Regulations.

The full assessment process

- 4.13 Regulation 21(5) of the 2012 Regulations is concerned with the full CHC assessment process. It provides:

“When carrying out an assessment of eligibility for NHS Continuing Healthcare, a relevant body must ensure that—

(a) a multi-disciplinary team—

- (i) undertakes an assessment of needs, or has undertaken an assessment of needs, that is an accurate reflection of that person’s needs at the date of the assessment of eligibility for NHS Continuing Healthcare, and
- (ii) uses that assessment of needs to complete the Decision Support Tool for NHS Continuing Healthcare issued by the Secretary of State and dated 28th November 2012; and

(b) the relevant body makes a decision as to whether that person has a primary health need in accordance with paragraph (7), using the completed Decision Support Tool to inform that decision”

- 4.14 Where a full CHC assessment is needed, the 2012 Regulations require an assessment by a multi-disciplinary team. There are a number of points to note:

- A multi-disciplinary team is defined in the Regulation 21(13) to mean a team consisting of either :

“(a) two professionals who are from different healthcare professions, or

(b) one professional who is from a healthcare profession and one person who is responsible for assessing persons for community care services under section 47 of the National Health Service and Community Care Act 1990”

- It is probably best practice to include a professional with a social care background where it is clinically appropriate to do so, but it is lawful to have a multi-disciplinary team with two different healthcare professionals.
- The role of the multi-disciplinary team is to carry out the assessment. However the team is not the final decision making body as to whether a patient qualifies for CHC. The team’s role is to complete the assessment process and to provide the information to the CCG, and thus support the CCG decision maker to decide whether the patient is eligible for CHC
- Membership of the team should be recorded with a full record is made of the conclusions of the team and the reasons for any recommendations that are put forward by the team.

4.15 The multi-disciplinary team are required to use the Decision Support Tool. In practice this means that the multi-disciplinary team needs to ensure that the paperwork is completed for each of the Care Domains. That involves an assessment of the level of need for each of the domains before a decision can be reached on CHC eligibility. The level of need for any Care Domain can be assessed at:

- Low
- Moderate
- High
- Severe
- Priority (for 4 of the care domains only)

4.16 The Decision Support Tool suggests that a patient is likely to be eligible for CHC if he or she has:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains.

4.17 However, the test for the decision maker under the 2012 Regulations is solely whether the patient has a “Primary Healthcare Need”. The multi-disciplinary team is usually expected to recommend that the patient has a “Primary Health Need” if the patient has a priority need in one domain or two or more instances of severe needs. However the Decision Support Tool only provides indicators to assist in the “Primary Healthcare Need” decision, but does not mandate an outcome.

4.18 The decision maker is fully entitled to conclude that, given the individual clinical circumstances, the patient does not have a Primary Health Need despite having a priority level of needs in one of the four domains that carry this level or two or more identified severe needs. The ultimate decision is a matter for the clinical judgment of the decision maker (usually a CHC panel acting as a decision maker on behalf of the CCG). The panel should be informed by the outcome of the DST as reported by the multi-disciplinary team, but must reach its own decision on the tests set out in the 2012 Regulations. The Guidance states that the assessment should not be carried out in a mechanistic way and, depending on the clinical facts, the team is entitled to recommend that the patient has a Primary Health Need if there is:

- one domain recorded as severe, together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs,

4.19 In these cases, the team needs to look at overall level and severity of medical needs, the interactions between needs in different care domains, and the evidence from risk assessments. All these should be taken into account in deciding whether to make a recommendation of eligibility for NHS Continuing Healthcare. The Guidance however notes that it is not possible to equate a number of incidences of one level with a number of incidences of another level. The team should not, for example conclude that ‘two moderates equals one high’.

4.20 Ultimately, the recommendation must be one of professional judgment by the multi-disciplinary team. It is therefore inevitable that there will be some variations between the assessments conducted by different professionals. A single set of national criteria and a single Decision Support Tool assist in improving consistency between decisions within a CCG and between different CCGs but some degree of inconsistency is inevitable given the professional judgments that need to be made within the multi-disciplinary team. Provided the assessments are carried out conscientiously, it is more important to carry out accurate assessments on the clinical information available than to be over concerned about consistency between this case and another which, however similar, cannot ever be identical.

Consultation with Social Services

4.21 Regulation 22(1) provides that CCGs must, as far as reasonably practicable, consult with Social Services before making a final decision about whether a patient qualifies for CHC. There is a duty on Social Services Departments to provide advice and assistance to CCGs when they are consulted. If the local authority has any paperwork concerning the patient including any assessment that a local authority has conducted to determine if the patient is in need of community care services, there is a duty on the local authority to disclose this to assist the CCG. The consultation stage should happen after the completion of the assessment using the Decision Support Tool but before the eligibility decision is made.

4.22 The CCG should provide as much information to the local authority about the case as the local authority reasonably requires. Provided assurances are given by both sides about maintaining professional confidentiality (which should not be a problem with professional social workers), the Data Protection Act 1998 should not prevent the flow of relevant clinical information between the local authority. The CCG can rely on the statutory duty to consult under Regulation 22 of the 2012 Regulations to justify the disclosure of sensitive personal data about the patient to the local authority. It thus appears that, unless there are very special circumstances, the local authority are entitled to see all the case papers concerning the patient to assist them to respond to the application for CHC.

4.23 However the local authority do not have an automatic right to see the information for other purposes, such as following up any concerns they may have about other service users. CCG staff should seek advice if they are concerned that there is a request from the local authority

or anyone else (including the police) to use the information collected in the CHC process for any purpose other than assessing if a patient is entitled to CHC.

4.24 The role of local authority at this stage is to have the chance to comment on the assessment and its recommendations, and to feed their views into the decision making process. But the local authority does not hold a veto. The CCG is the sole decision maker on CHC eligibility as the Court of Appeal confirmed in *St Helens Borough Council v Manchester Primary Care Trust & Anor*¹⁰ [2008] EWCA Civ 931 (06 August 2008).

4.25 The CCG must take any views expressed by local authority colleagues into account when taking the CHC eligibility decision. However, the tensions between the CCG and the local authority can mean that the CCG ends up disagreeing with the local authority's views on the right outcome of an individual case. The local authority may consider that a patient is eligible for CHC and thus seek to press the CCG to fund a patient's on-going care (supported by the patient and/or the family). However, it is not unknown for the CCG to disagree with views strongly expressed by local authority colleagues. Any such disagreement should not prevent the CCG making a decision because the duty on the CCG under the Regulations is to consult the local authority, which does not require consensus decision making. The local authority holds no veto and the decision making process should not be set up so as to give the local authority a veto. However Regulation 22(2) provides:

"Where there is a dispute between a relevant body and the relevant social services authority about—

- (a) a decision as to eligibility for NHS Continuing Healthcare; or
- (b) where a person is not eligible for NHS Continuing Healthcare, the contribution of a relevant body or social services authority to a joint package of care for that person,

the relevant body must, having regard to the National Framework, agree a dispute resolution procedure with the relevant social services authority, and resolve the disagreement in accordance with that procedure"

¹⁰¹⁰ <http://www.bailii.org/ew/cases/EWCA/Civ/2008/931.html> [should just be fn 8 not 88]

4.26 Paragraph 156 of the National Framework provides:

“CCGs and LAs in each local area should agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS continuing healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (see Annex F). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to LAs and CCGs in different geographical areas, the disputes resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved”

4.27 That approach begs the question as to what happens if the CCG and the local authority have not been able to agree local dispute resolution protocols as has happened in a number of areas. In those circumstances, there is probably a duty on the CCG to offer a form of mediation. However, as the Court of Appeal made clear in *St Helens Borough Council v Manchester Primary Care Trust & Anor*¹¹ [2008] EWCA Civ 931, the NHS body is the ultimate decision maker and its decision will only be set aside if the court considers that it is a *Wednesbury* unreasonable decision.

4.28 If the local authority fail to respond to a request to provide input into the CHC process relating to a particular patient, the CCG are entitled to press ahead to the decision making phase without the local authority input.

Who within the CCG makes the eligibility decision?

4.29 The eligibility decision can be made by a person or committee authorised under the CCG’s Standing Orders to take the decision on behalf of the CCG. This will usually be a nominated officer or a panel which is constituted to review the assessments and reach a decision. There is considerable flexibility in the Department of Health Model Standing Orders for CCGs to permit CCGs to delegate decision making by a CCG to a committee which includes individuals

¹¹¹¹ <http://www.bailii.org/ew/cases/EWCA/Civ/2008/931.html> [should just be fn 9 not 99]

who are not employed by the CCG. Thus, the CCG panel could include colleagues from Social Services or patient user groups, provided that the body is constituted as a committee of the CCG.

- 4.30 The membership, terms of reference and decision making powers of the Panel should be approved by the CCG Governing Body. Many CCGs have colleagues from Social Services on the panel which makes the final decisions on eligibility, but it is not appropriate to set up the decision making process of the committee in such a way that those from outside the CCG have a right of veto or constitute a majority for an vote on the issue of eligibility. The CCG should not leave itself in a position where CCG staff are unable to take a decision that a patient is or is not eligible for CHC.

The tests to be applied in determining eligibility for CHC

The first ground: Primary Health Need

- 4.31 Regulation 21(5)(b) provides that the purpose of the Decision Support Tool is to “inform” the decision of the CCG as to whether the patient has a “primary health need”. Regulation 21(6) then provides:

“If a relevant body decides that a person has a primary health need in accordance with paragraph (5)(b), it must also decide that that person is eligible for NHS Continuing Healthcare”

- 4.32 The CCG’s judgment as to whether a person has a primary health need will be reached in part by looking at the medical support the patient requires on a day to day basis to meet their needs using the assessment produced by the Decision Support Tool. Paragraph 35 of the National Framework states that a primary healthcare need is assessed according to the following aspects of a patient’s needs:

- **Nature:** the type of needs, and the overall effect of those needs on the individual, including the type (“quality”) of interventions required to manage them;
- **Intensity:** both the extent (“quantity”) and severity (degree) of the needs, including the need for sustained care (“continuity”);
- **Complexity:** how the needs arise and interact to increase the skill needed to monitor and manage the care;
- **Unpredictability:** the degree to which needs fluctuate, creating difficulty in managing needs; and the level of risk to the person’s health if adequate and timely care is not provided.

4.33 Paragraph 36 of the National Framework goes on to state that:

“Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual’s needs”

4.34 For the vast majority of cases, this is substantially the procedure that has been followed under the previous criteria for determining CHC eligibility. Panels should bear in mind that all sick and vulnerable adults require a level of social support and, if they cannot be cared for in their own homes or with relatives, have a need for suitable accommodation. Patients with complex medical conditions will inevitably need a measure of daily healthcare support as well. The panel must focus on what the patient needs at this time. For many patients there is a possibility that their condition will change in the near future. The patient may improve or his or her medical condition may deteriorate. If this happens then eligibility for CHC can be reconsidered when the changed facts are known. However, the panel needs to make a decision on the patient’s clinical condition as it is at that date. A patient should not qualify for CHC because they have a medical condition which, if not managed properly, may be life

threatening or require intensive medical intervention. The panel should focus on the nature, intensity, complexity and unpredictability of the patient's condition at that point to determine eligibility for CHC.

4.35 There are particularly difficult issues where a patient is deteriorating. Paragraph 38 of the National Framework provides as follows:

It is also important that deterioration is taken into account when considering eligibility, including circumstances where deterioration might reasonably be regarded as likely in the near future. This can be reflected in several ways:

- Where it is considered that deterioration can reasonably be anticipated to occur before the next planned review, this should be documented and taken into account. This could result in immediate eligibility for NHS continuing healthcare (i.e. before the deterioration has actually occurred). The anticipated deterioration could be indicative of complex or unpredictable needs.
- Where eligibility is not established at the present time, the likely deterioration could be reflected in a recommendation for an early review, in order to establish whether the individual then satisfies the eligibility criteria.
- If an individual has a rapidly deteriorating condition that may be entering a terminal phase, they may need NHS continuing healthcare funding to enable their needs to be met urgently (e.g. to allow them to go home to die or appropriate end of life support to be put in place). This would be a primary health need because of the rate of deterioration. In all cases where an individual has such needs, consideration should be given to use of the Fast Track Pathway Tool, as set out in paragraphs 97 – 107.
- Even when an individual does not satisfy the criteria for use of the Fast Track Pathway Tool, one or more of the characteristics listed in paragraph 35 may well apply to those people approaching the end of their lives, and eligibility should always be considered"

4.36 A balance of medical and non-medical needs need is probably not sufficient to lead to a conclusion that the patient has a primary health need. The issue for the CCG is whether the

above factors suggest that the patient's main or predominant need is for healthcare support, with a subsidiary need for accommodation and social care, or whether the patient has a main or predominant need for accommodation and social care, albeit that the patient also has a variety of healthcare needs. There will be cases where a patient with a complex medical condition is properly managed by staff who know the patient very well. This may lead to a situation where a previously unpredictable medical condition is now much less uncertain. It may mean that the intensity and severity of the patient's needs is less than it was a few months previously. Panels need to give proper recognition to carers who are able to bring about such benefits and should not underestimate the complexity of the patient's condition because it is managed predominantly by non-specialist staff. However it should give due weight to such improvements and may well conclude that, as a result, the patient no longer qualifies for CHC. The issue should always come back to the single issue as to whether the patient has a primary health need.

- 4.37 The setting in which the patient is provided with care is not usually relevant to a decision about CHC entitlement. CHC can be provided to patients in their own home or in a care home.

The second ground: Needs beyond what a Local Authority can be expected to provide

- 4.38 Regulation 21(7) of the 2012 Regulations picks up the tests outlined in *Coughlan* and requires the CCG to apply them. It provides:

"In deciding whether a person has a primary health need in accordance with paragraph (5)(b), a relevant body must consider whether the nursing or other health services required by that person are—

- (a) where that person is, or is to be, accommodated in relevant premises, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
- (b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide,

and, if it decides that the nursing or other health services required do, when considered in their totality, fall within sub-paragraph (a) or (b), it must decide that that person has a primary health need”

4.39 It follows that, in reaching the decision as to whether a patient has a primary health need, the CCG is required to take two further steps. The CCG is required to look at the “*nursing or other health services required by that person*” and then ask itself 2 questions. First, the CCG must ask itself if the person is in a care home or is required to be placed in a care home, the CCG needs to ask itself whether the individual’s needs are:

“more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person’s means, under a duty to provide”

4.40 If the patient does have a need for “*nursing or other health services*” which is more than is appropriate to be provided within social care accommodation, the CCG is required to reach the conclusion that the patient has a primary health need and hence is eligible for CHC.

4.41 If the patient is not in a care home (which will usually mean that the person is in their own home) the CCG is required to look at the “*nursing or other health services required by that person*” and ask whether these needs are of a nature beyond which a social services authority could be expected to provide, then the CCG must find that the patient is eligible for CHC.

4.42 It is good practice to have these questions set out on the form that those undertaking the assessment have to complete to ensure that the CCG addresses its mind to them as part of the assessment process. The thinking in this part of the Regulation (which is identical to the Directions which preceded the Regulations), emerges from the observations of the Court of Appeal in *R (ota Coughlan) v North and East Devon Health Authority*¹². The wording means that if the CCG decides that, looking at the patient’s needs as a whole, it is inappropriate to look to social services to provide day to day care for the person, the CCG is required to conclude that the patient qualifies for CHC.

4.43 These provisions exist to ensure that patients are not left in circumstances where their needs are not serious enough to satisfy for CHC but their nursing or other health service needs are too medically complex to be provided by a local authority. However CCG panels need to bear a number of points in mind when addressing this issue:

- There are a wide range of health functions which local authorities are required to provide under a variety of statutes. The details are set out below. The range and quality of health and health related services that local authorities can provide appears to be far greater than some local authorities assume;
- The test asks the CCG to focus on what the CCG considers it is reasonable to ask the local Social Services to provide. That may well be a higher or lower level of services than the local authority social services in fact provide. The range of service users supported by the social services department of a local authority may be more generous in their provision of services than the CCG considers is reasonable. In that case, a patient may qualify for CHC even if the local social services could have provided support for the patient. Equally, however local authority social services cannot cut back on social care provision and thereby seek to shift patients from social to health care by simply failing to provide classes of services. If the CCG considers that a patient's needs could properly be met by the local authority (even if the local authority social services may refuse to provide such services) it may be entirely appropriate for the CCG to decline to provide CHC support for the patient.
- The NHS does not walk away from a patient if the patient is not eligible for CHC. CCGs provide a wide range of medical support services to a patient in a nursing home or in the community who do not qualify for CHC, including NHS funded nursing care.

5 NHS Funded Nursing Care

5.1 NHS Funded Nursing care is covered by Part 6 of the 2012 Regulations. Regulation 20 defines "nursing care" as follows:

¹² [2001] QC 213.

“nursing care” means nursing care by a registered nurse and “nursing care by a registered nurse” has the same meaning as in section 49(2) of the Health and Social Care Act 2001”

5.2 The definition of “nursing care” in section 49 of the 2001 Act is:

“In this section “nursing care by a registered nurse” means any services provided by a registered nurse and involving–

(a) the provision of care, or

(b) the planning, supervision or delegation of the provision of care,

other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse”

5.3 Regulation 28 defines the decision making process for determining if a patient is eligible for NHS funded nursing care as follows:

“28.—(1) Subject to paragraphs (2) and (3), where it appears to a relevant body in respect of a person for whom it has responsibility that that person—

(a) is resident in relevant premises or may need to become resident in such premises; and

(b) may be in need of nursing care,

that body must carry out an assessment of the need for nursing care.

(2) Before carrying out an assessment under paragraph (1), the relevant body must consider whether its duty under regulation 21(2) is engaged, and if so, it must comply with the requirements of regulation 21 prior to carrying out any assessment under this regulation.

(3) Paragraph (1) does not apply if a relevant body has made arrangements for providing the person with NHS Continuing Healthcare.

(4) Where—

(a) the relevant body has carried out an assessment pursuant to regulation 21(2); but

(b) paragraph (3) does not apply because a decision has been made that the person is not eligible for NHS Continuing Healthcare,

that body must nevertheless use that assessment, wherever reasonably practicable, in making its assessment under paragraph (1).

(5) Where—

(a) the relevant body determines that a person has a need for nursing care pursuant to this regulation; and

(b) the person has agreed with that body that that person does want to be provided with such nursing care,

paragraph (6) applies.

(6) The relevant body must pay to a registered person for the relevant premises the flat rate in respect of that person's nursing care unless or until that person—

(a) has their need for nursing care assessed and it is determined that that person no longer has any need for nursing care;

(c) is no longer resident in the relevant premises;

(d) becomes eligible for NHS Continuing Healthcare pursuant to this Part;
or

(e) dies"

5.4 This Regulation makes it clear that NHS funded nursing care is an NHS contribution towards the cost of care home fees for patient that are not eligible for fully funded CHC. Patients cannot qualify both for CHC and NHS funded nursing care: see Regulation 28(3). Patients who have a need for nursing services but live at home do not qualify for the payment. This provision assumes that a patient living in their own home who needs nursing services will

have those provided by district nurses or by a domiciliary care agency which is contracted by the relevant CCG to provide this service.

- 5.5 Regulation 28 imposes a duty on the CCG (or possibly NHS England) to carry out an assessment of the patient's need for nursing care. However Regulation 28(4) provides that where a patient is found not to be eligible for CHC, the CHC assessment or the CHC Checklist should be used to determine the patient's eligibility for NHS funded nursing care.
- 5.6 The level of payment in November 2016 is £156.25 per week (supposedly on an "interim basis"). Before October 1 2007, there were three different levels or bands of payment for NHS-funded nursing care – low, medium and high. If a patient moved into a care home before October 1 2007, and was awarded the low or medium bands, the patient should have been transferred to the standard rate from that date. If the patient moved into a care home before October 1 2007 and was awarded the high band, NHS-funded nursing care continues to be paid at the higher rate. For 2015/16, the higher rate is £154.14 a week. Patients are entitled¹³ to continue on this rate unless:
- a) The patient no longer has nursing needs;
 - b) The patient no longer lives in a care home that provides nursing;
 - c) The patient's nursing needs have reduced and, applying the previous tests, he or she is would no longer be eligible for the high band. In that case the patient will drop to the standard rate of £112.00 a week, or
 - d) The patient becomes entitled to CHC.

6 The relationship between NHS and local authority funded services.

- 6.1 Aside from care delivered to a patient by a registered nurse (which cannot be delivered by the local authority) or care by a doctor, there is a very wide range of both general and, on

¹³ The entitlement is set out on the NHS Choice website at <http://www.nhs.uk/chq/Pages/what-is-nhs-funded-nursing-care.aspx>

occasions, highly specialised community care services that a CCG can expect to be provided to sick and disabled people by a local authority, whether in a community or in a care home setting. The wide description of services that a local authority can provide was previously in Schedule 20 to the National Health Service Act 2006 which provided that community care services to be provided by local authorities include:

“the provision, for persons whose care is undertaken with a view to preventing them from becoming ill, persons suffering from illness and persons who have been suffering from illness, of centres or other facilities for training them or keeping them suitably occupied and the equipment and maintenance of such centres”

- 6.2 This Schedule has been repealed following the implementation of the Care Act 2014 but the wide duties under the Care Act 2014 substantially replicate the duties set out in the NHS Act.
- 6.3 It is sometimes suggested that the care of people who are sick or develop chronic conditions falls exclusively on the NHS. However, this is not the statutory position. There is a long history of the care of the vulnerable, including those with chronic illnesses or disabilities, falling on the local authority. The NHS was, to a great extent, formed out of local authority organised services in the 1940s and local authorities continued to play a key part in long term care of the sick and vulnerable. This is continued in the National Health Service 2006 Act and in legislation which provide that local authorities still play a crucial role in healthcare. In particular, local authorities provide public health services under the NHS Act.
- 6.4 If a package of care services is needed to support someone who is disabled or ill, or to prevent them getting ill, and the care is of such a nature that it does not require a substantial and regular care input by a registered nurse or doctor, the primary duty lies on the local authority. There is, for example, a wide range of duties to the sick and disabled on local authorities under the Care Act 2014.
- 6.5 However, where a patient is eligible for CHC, a local authority will generally decide that the patient has no “need” for community care services because a package of accommodation, social and health care service should be funded by the NHS to meet all of the service user’s eligible needs.

7 Reviews and appeals to NHS England by patients or relatives on eligibility grounds.

7.1 Regulation 21(11) of the 2012 Regulations provides for the patient to be informed of the CHC decision as follows:

“(11) Where a relevant body has decided that a person is not eligible for NHS Continuing Healthcare, it must inform the person (or someone acting on that person’s behalf) of the circumstances and manner in which that person may apply for a review of the decision if they are dissatisfied with—

(a) the procedure followed by the relevant body in reaching that decision; or

(b) the primary health need decision made in accordance with paragraph (5)(b)”

7.2 Unlike other provisions within the 2012 Regulations, Regulation 21(11) does not specifically require the CCG to give reasons for its decision. However paragraph 146 of the National Framework states:

“the CCG should give clear reasons for its decision”

The duty to have regard to the National Framework thus probably means that the CCG has a legal duty to give coherent reasons for its eligibility decision.

7.3 Regulation 21(11) provides that the patient must be told that he or she can seek a review of the decision. Para 151 of the National Framework provides

Each CCG should agree a local review process. These review processes should include timescales and should be made publicly available, and a copy should be sent to anybody who requests a review of a decision”

7.4 The CCG should devise and operate a procedure to enable staff who were not involved in the original decision to review decisions on CHC eligibility. This should be undertaken as quickly

and thoroughly as is possible in the circumstances. This will rarely require the CCG to repeat the multi-disciplinary assessment though, if there are areas of substantial concern identified in the review, this review process may lead to the CCG re-running the assessment process. Once the review is completed, the CCG should provide a response to the patient or their relatives explaining the decision that has been reached and the reasons for the decision.

- 7.5 If the patient or their relatives remain dissatisfied with the decision, they can appeal to a panel set up by NHS England (which replaces the SHA panels which have been in existence since 2001) which is under a duty to “review” the decision: see Regulation 23 of the 2012 Regulations. Regulations 23(8) and (9) provide that the CCG must follow the recommendation of the NHS England Review Panel unless it has exceptional reasons not to do so. Those “exceptional reasons” could be that the Review Panel has failed to apply the National Framework properly, has failed properly to understand the assessments that the CCG made of the patient’s needs or has come to an irrational conclusion.
- 7.6 CCG staff should co-operate fully with the operation of such panels which will make final decisions on entitlement to CHC.
- 7.7 If the NHS England appeal panel decides that the patient is eligible for CHC and that decision is accepted by the CCG, the CCG has a liability to meet the costs from the date of the decision. If the decision making process has taken more than 28 days, the CCG should reimburse the patient or family members for relevant care and accommodation costs involved from 28 days after the date when an application was made to the CCG for CHC support. If the CCG turns down the patient for CHC and this decision is reversed by the NHS England panel, an ex-gratia payment should be made to cover the costs incurred by whoever has funded the care whilst the decision making process was continuing: see paragraph 18 of Annex F to the National Framework.
- 7.8 A CCG is highly unlikely to have any responsibility to have a duty to meet care costs incurred before the date when an application was made to the CCG for CHC support.

Support for the patient whilst the review or appeal procedure is continuing

- 7.9 If the CCG makes the decision that a patient is not entitled to CHC, the CCG should nonetheless provide a package of appropriate health care for the patient but should refuse to enter into new agreements to fund accommodation or social care costs. There can be considerable difficulties if the patient is waiting to be discharged from hospital and there is a dispute with either the relatives or social services about a package of services at home or about meeting care home fees whilst the review procedures are being carried through.
- 7.10 There are a number of options that CCGs can consider in such circumstances:
- a) It may be possible to agree with the local authority that the patient should go to a care home or have a package of domiciliary care at home to be funded by either the local authority or the CCG, and the paying party will be reimbursed by the CCG or local authority for the care home costs if the NHS England appeal is upheld; or
 - b) The same arrangement could be reached with the patient or with family members. Under such an arrangement the CCG could enter into a similar arrangement with the patient or relatives to meet the costs in short term, and for the CCG to be reimbursed if appeal is unsuccessful.
- 7.11 If agreement cannot be reached for any of the above options and this is preventing a patient being discharged from in-patient care, then the CCG should serve notices on Social Services under the Community Care (Delayed Discharges etc) Act 2003. The Guidance provided by the Department of Health¹⁴ on serving notices makes it clear that notices must be withdrawn if it is later determined that a patient does qualify for CHC. However the existence of a dispute with either the local authority or with the patient (or their relatives) is not a good reason for holding back from serving notices.
- 7.12 If the patient or their relatives makes it clear to Social Services that they do not wish to seek support from social services then the local authority generally have no duty to arrange accommodation for the patient. In those circumstances the usual route is for the either the CCG or the Acute Trust to seek legal advice about evicting the patient from the in-patient bed.

¹⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4064934

A patient who remains in an NHS hospital bed after the time when the NHS Trust has decided that the patient has clinical needs to justify the bed is a trespasser. If necessary, an eviction order can be obtained from the county court: see *Barnet PCT v X* [2006] EWHC 787 (QB).

8 Resolving disputes with local authorities (including interim funding).

8.1 Unlike patients or their relatives, local authorities are unable to appeal to NHS England panels. Disputes between local authorities and CCGs need to be resolved using dispute resolution procedures agreed between the two public bodies. Paragraph 159 of the National Framework provides:

“CCGs and LAs in each local area should agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS continuing healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (see Annex F). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to LAs and CCGs in different geographical areas, the disputes resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved”

8.2 Annex F to the National Framework sets out the general statutory duties imposed on both NHS bodies and local authorities and urges them to comply with those duties until a CHC eligibility decision is made. It provides at paragraph 7:

“No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities”

8.3 Regulation 22(2) of the 2102 Regulations provides:

“(2) Where there is a dispute between a relevant body and the relevant social services authority about—

- (a) a decision as to eligibility for NHS Continuing Healthcare; or
- (b) where a person is not eligible for NHS Continuing Healthcare, the contribution of a relevant body or social services authority to a joint package of care for that person,

the relevant body must, having regard to the National Framework, agree a dispute resolution procedure with the relevant social services authority, and resolve the disagreement in accordance with that procedure”

8.4 Paragraph 19 of Annex F to the National Framework provides some more detail about dispute resolution procedures as follows:

“It is important that the Board/ CCGs and LAs have clear jointly agreed local processes for resolving any disputes that arise between them on the issues covered in this guidance. The Standing Rules Regulations and Directions to LAs require the Board or CCGs and LAs to have an agreed local process for resolving disputes between them on issues relating to eligibility for NHS continuing healthcare and for the NHS elements of joint packages. The Board, CCGs and LAs could extend the remit of their local disputes process to include disputes over refunds. Whatever disputes process is selected, it is important that it should not simply be a forum for further discussion but includes an identified mechanism for final resolution, such as referring the case to another CCG and LA and agreeing to accept their recommendation”

8.5 However, the references to “dispute resolution procedures” are somewhat problematic because the CCG must remain as the ultimate decision maker throughout the process. They provide, in effect, a further opportunity for the local authority to require the CCG to examine its own decision. They should cover:

- a) Who in the local authority and CCG should review the dispute in the first instance;
- b) An agreed timetable for that review;
- c) A set of principles to guide the review which should include a recognition that it is not the role of the CCG to take decisions which are the statutory responsibility of the local

authority and that it is not the role of the local authority to take decisions which are the statutory responsibility of the CCG, but that either body can ask the other to review their decisions;

- d) An agreed process for the involvement of senior officers in the process;
- e) An agreement that, in the event that the review procedures changes or modifies a decision, one public body will provide full reimbursement to the other in an agreed form over the relevant period without the need to review the details of the expenditure or determine whether such expenditure would have been met by that body, together with interest;
- f) An agreement to refer disputes to mediation (possibly with an independent legal view being provided if that is needed) if the dispute cannot be resolved by this process.

8.6 However, the reality is that there are many CCGs and local authorities where protocols are not in place between CCGs and local authorities. There are many model policies in existence but the [Sheffield CCG policy](#) is an example of one which is straightforward and sensible.

9 **What package of services should be provided to a CHC eligible patient?**

9.1 The CCG has two different types of decision to make:

- a) Does the patient qualify for CHC?; and
- b) If the patient does qualify, what package of support should be provided by the CCG and others including the local authority to support the patient?

9.2 It is important to distinguish between these decisions. Eligibility for CHC is not a “blank cheque” which means that every one of the patient’s social and healthcare needs are required to be met by the NHS. These services need to be subject to strict cost-effectiveness tests in the same way as the provision of all other NHS services are subject to such tests. Once a CCG has reached a decision that a patient is eligible for CHC, it is necessary for the

CCG to decide what services should be provided to support the patient. The fact that a patient is eligible for CHC means that the patient has an entitlement to a package of services from the CCG. That the package is likely to include a range of social care services as well as health services as explained above.

Choice of accommodation

9.3 Although some patients who are eligible for CHC are supported in their own homes, many patients need to be provided with accommodation as part a package of services. It is good practice for CCG policies to cover the issue of choice of accommodation and some CCGs follow the scheme set out in Annex A to the Statutory Guidance under the Care Act 2014¹⁵. However, the patient's choice must be subject to certain conditions. A number of CCGs have policies which set up a series of conditions for considering choice of accommodation for CHC patients which CCGs may wish to adopt along the following lines:

- a) Having regard to the CQC registration and inspection reports, does the preferred accommodation appear to the CCG to be suitable in relation to the patient's needs as assessed by the CCG?
- b) Would the cost of making arrangements for the patient at the preferred accommodation require the CCG to pay more than they would usually expect to pay having regard to the patient's assessed needs?
- c) Is the preferred accommodation available?
- d) Are the persons in charge of the preferred accommodation willing and able to provide it to the patient subject to the CCG usual terms and conditions, having regard to the nature of the accommodation, for providing accommodation for such a person for NHS Continuing Healthcare?

¹⁵ See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

- 9.4 If the above approach is followed, CCG policies provide that the CCG usually place the patient in his or her preferred care home. This could be in another part of the UK if, for example, the patient has reached a stage in life where their priority is to live near a relative.
- 9.5 The patient's article 8 rights are engaged in any placement decision making process, and so the CCG would only be entitled to insist on being placed in another care home if the preferred care home failed the above tests. There is a particular problem where a patient is living in a care home where the fees are higher than the CCG considers that it ought to pay to provide services to the patient. The CCG may offer of a package of services for the patient at a different and less expensive home and thus discharge its statutory duty. Patients are not obliged to accept NHS services and the CCG discharges its duties to a patient if it makes an offer of a package of services, including accommodation, to a patient.
- 9.6 There is no presumption in the CHC scheme that the offer of a package of services is required to include supporting the patient in their present home and there is no absolute right under Article 8 ECHR to stay in the patient's own home. Whilst the preferences of the patient are an important factor which the CCG needs to take into account in making the overall decision, cost is also a key factor: see *Gunter v. South Western Staffordshire PCT* [2005] EWHC 1894 (Admin)¹⁶.
- 9.7 This is a complex and contentious area, and it would be helpful if CCG policies, endorsed by the CCG Governing Body, made this policy position clear from the outset. CCGs need to ensure that there is a measure of equity in the levels investment provided by the CCG in supporting different groups of patients. This can therefore mean that:
- a) The CCG offers to discharge its duty by providing a package of services for a patient in a care or nursing home which is not their preferred home. The CCG offers to discharge its duty to a patient who, to date, has had a package of services in their own home by moving the patient to a care home (since the costs of providing such care may be significantly less than providing care for an isolated individual patient); or

¹⁶ See <http://www.bailii.org/ew/cases/EWHC/Admin/2005/1894.html>

- b) The CCG offers to provide a package of domiciliary care services in the patient's own home which is the same broad cost of a package of services in a care home and either (i) the patient funds the provision of other services from his own resources, which can typically be a personal injury payout, (ii) relatives or family members agree to provide additional support to fill any gaps left by NHS provision which is not being provided or (iii) the patient is content to accept a service which is less than required to meet his assessed needs but prefers to accept such a package than move to a care home.

9.8 If agreement cannot be reached with the patient on a package of domiciliary care services in the patient's own home and the CCG continues to offer a care home placement that the patient refuses, the CCG will discharge its legal duties to the patient by offering the care home placement (albeit that this placement is refused). In such circumstances the CCG can lawfully withdraw an existing package of domiciliary care services in the patient's own home.

No top up fees or fee sharing for NHS services

9.9 There is a key difference between NHS and social services care in that there is no provision within the NHS for cost sharing or for families to provide top up fees. NHS services must be provided free of charge and fee sharing is not permissible for core NHS services¹⁷. The NHS Choices website¹⁸ explains:

"Is it possible to pay top-up fees for NHS continuing healthcare?"

No, it is not possible to top up NHS continuing healthcare packages, like you can with local authority care packages.

The only way that NHS continuing healthcare packages can be topped up privately is if you pay for additional private services on top of the services you get from the NHS. These private services should be provided by different staff and preferably in a different setting"

9.10 It may be permissible for the patient or relatives to agree a package of additional services with the care home owners (such as a visits from a chiropodist, hairdresser or even to pay for

¹⁷ See section 1(3) of the National Health Service Act 2006.

a larger room). See for example *S v Dudley PCT* [2009] EWHC 1780 (Admin)¹⁹. However, if the care home is to be used, the CCG should be able to enter into a contract with the home owners which is capable of standing on its own without the support of others.

10 Contracting with care homes and other providers of care under CHC

10.1 If the CCG agrees to provide care to a patient at a care home, a written contract in the form of an NHS Standard Contract should be entered into between care home and the CCG. CCGs are under a statutory duty to use the NHS Standard Contract: see part 5 of the 2012 Regulations and the NHS England Technical Guidance²⁰.

10.2 The contract should set out the level of service that the home agrees to provide, define clinical governance regimes, review mechanisms and the price to be paid. It should limit the extent to which the care home can increase the fees and require the care home to report to the CCG if the patient's medical condition changes.

10.3 From April 2016, CCGs have been permitted to use the Shorter Form Contract²¹. However, this contract is still 70 pages long and so is only "shorter" than the full contract that runs to over 200 pages.

11 Direct Payments for CHC patients.

11.1 Patients who have long term conditions which require support from either the NHS or social services are entitled to have sums paid to them and then, in effect, to purchase and arrange their own care under a system of direct payments. The system for NHS direct payments is now governed by the National Health Service (Direct Payments) Regulations 2013 (as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013). There will be a separate chapter about direct payments and the inter-relationship between CHC and direct payments is considered in that chapter.

¹⁸ See <http://www.nhs.uk/conditions/social-care-and-support-guide/pages/nhs-continuing-care.aspx>

¹⁹ This case is reported on Lawtel and LexisNexis but not in any open source website.

²⁰ See <https://www.england.nhs.uk/nhs-standard-contract/16-17/>

²¹ See <https://www.england.nhs.uk/wp-content/uploads/2016/04/nhse-contracts-shrt frm-guid.pdf>

11.2 Direct payments can often deliver value for money to the local authority, properly reward members of the family who provide voluntary care and give control to patients and their families. It can result in carers being directly employed by the service user. Patients who are entitled to CHC are entitled to seek a direct payment from April 2014²². The amount of the direct payment must be:

“sufficient to provide for the full cost of each of the services specified in the care plan”

11.3 It is hard to see how a direct payment can be appropriate where a CHC patient is accommodated in a care home. However direct payments can be used by CHC eligible patients who live in their own homes or in supported living.

12 Providing a care package into a patient’s home.

12.1 If the patient is to be provided with a care package in his own home, the details of the care to be provided should be set out clearly in a care plan which describes the level of service to be provided to the patient and how it is to be delivered. CCGs are entitled to contract out such care packages to domiciliary care providers. If this happens, the CCG should ensure there is an NHS Standard Contract (possibly in the shorter form) between the domiciliary care provider and the CCG which covers the same areas as a contract with a care home (See above).

12.2 Where the CCG delivers care using its own staff, it needs a clear policy about the approach to be taken by its staff in designing packages to support patients in their own homes. Whilst there can be enormous merit for both the patient and the CCG in maintaining the patient at home (and the CCG does not need to pay for accommodation costs) as patients with chronic conditions require an increasing level of services there can come a time when the overall cost of the package is substantially higher than providing services to patients in a nursing home.

²² This is explained in the statutory guidance which is at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

There can also be significant problems with sustaining staff in a home if there are continuous disagreements between carers and the patient and/or their family.

- 12.3 The CCG needs to be mindful that, if it is using its own staff to deliver services in the patient's own home this means that the patient's home is the CCG employee's place of work. The CCG should be mindful of the need to balance its duties to the patient with the duty to provide the member of staff with a reasonably safe place of work.
- 12.4 Problems can arise if the CCG uses staff to deliver care in a patient's own home. The patient's home is the staff's place of work and the CCG therefore has a duty to deliver a reasonably safe place of work for its staff. The duties to staff are not defined by the best interest of the patient but exist independently of such obligations. There are a series of issues that CCG managers should consider:
- a) **The interests and rights of other occupants of the home:** A CHC package can only be delivered to a patient in their own home if the legal owners of the home agree to staff coming into the home to deliver care. Where the patient is not the legal owner of the property, clear agreement is needed from the property owner to enable care to be delivered. The CCG should ensure that it is not left in the position where care staff do not have unimpeded access to the property;
 - b) **Health and Safety issues:** The CCG must consider whether the patient's home is a reasonably safe environment for staff to work in. Whilst some allowance can be made for the fact that the home environment does not need to be maintained to the same standard as a hospital, a risk assessment should be carried out and action taken to avoid any very obvious risks. The patient's home needs to be a reasonably safe place of work for that particular member of staff. So if, for example, a member of staff is allergic to dog hair and the patient has a dog, it would be unreasonable to expect that member of staff to work in the patient's home even if would be fine for others.
 - c) **Harassment Issues:** Predictable and/or repeated harassment from the patient, members of the patient's family or visitors could leave the CCG or a domiciliary care provider in breach of its duty to its own staff. Whilst some allowance must be made to

permit the patient to live life in their own way, verbal or physical abuse, racially or sexually improper comments or any other action which is designed or likely to impede staff in their ability to deliver care must be addressed by the CCG. In extreme cases, this can arise where members of the patient's family (who may be expert in managing the patient's medical condition) are so insistent on their own ways of doing things and/or can be so directing that they impede the ability of staff to do their job. These problems require balancing duties to staff with duties to patients. If CCG staff are aware of these types of problems they should report them and seek advice and support without delay.

- 12.5 Whilst CCG decision makers obviously wish to do the best for individual patients, they should also bear in mind that the CCG has a statutory duty under the NHS Act to break even financially. This means that the services that the CCG is able to provide under section 3 are inevitably subject to a degree of rationing or prioritisation (as is the case with all NHS provided health services and indeed virtually all health services across the world). Thus if the CCG has reached the point where it would be able to provide an appropriate package of care for a patient in a care home at a significantly lower cost, CCG staff should look very carefully to decide whether it is justifiable under their own policies to pay a higher sum to maintain the patient in his or her own home. This is an area where specialist legal advice is often sought.

The extent of services (other than accommodation) that are required to be provided as part of the CHC package.

- 12.6 Patients often require a wide range of nursing and other services as part of a package of CHC. Whilst this needs to be considered on a case by case basis, CCGs should be mindful that they have a duty to act fairly between different classes of patients and there are many patients whose healthcare needs cannot be fulfilled by the NHS, either in part or in whole. An assessment may, for example, indicate that a patient has a need for 10 hours nursing support a week. That assessment does not lead to a statutory duty to provide 10 hours support a week. The CCG has a statutory duty to break even financially each year and is entitled to apply its policies fairly and to provide a package of support which is consistent with the level

of support provided to other patients²³. That may, in the above example, mean that the CCG is only able to offer 5 hours nursing support a week. Provided the CCG has followed its own procedures it is highly unlikely that such a decision could be challenged in the courts. As Mr. Justice Ousley said in *T & Ors, R (on the application of) v London Borough of Haringey*²⁴:

“If [*the CCG*] is providing the resources, it is entitled to decide how they should be used”

12.7 CCGs should have policies to assist officers making decisions about what level of support should be provided to patients who qualify for CHC. In reaching these decisions it is entirely proper and probably inevitable that the CCG will take into account the cost of services. The courts have consistently upheld the right of NHS bodies to ration services for patients so that the CCG can make a rational and fair allocation of services to the wide range of people that it needs to serve out of its limited budget.

13 Support for patients who do not qualify for CHC or NHS funded care.

13.1 If a patient does not qualify for CHC, the NHS is under no obligation to meet all or any part of the accommodation or social care costs of a patient who is not in hospital. However, the CCG may still be responsible for providing a broad range of healthcare services to the patient, including offering to provide primary care services from a GP practice. Thus, the CCG is obliged to consider how much of the healthcare needs it is able to meet, including meeting nursing needs and to balance those needs against the other demands on its budget.

13.2 The Guidance states that, for patients who do not qualify for CHC includes the following:

“The range of services which the NHS is expected to arrange and fund includes but is not limited to:

- Primary health care
- Assessment involving doctors and registered nurses

²³ See the observations of Mr. Justice Ouseley in *T & Ors, R (on the application of) v London Borough of Haringey* [2005] EWHC 2235 (Admin).

²⁴ See footnote 13.

- Rehabilitation and recovery (where this forms part of an overall package of NHS care as distinct from intermediate care)
- Respite health care
- Community health services
- Specialist health care support
- Palliative care”

13.3 If a patient does not qualify for CHC, the local authority may have a responsibility for providing such social care, including personal care, to the patient (depending on the patient’s circumstances and the local authority’s policies). The local authority cannot be expected to provide specialist NHS care (either in quantity or quality). However, if the CCG has properly followed the Responsibilities Directions as set out in paragraphs 9 to 10 above, the issue as to whether the patient needs specialist care which is beyond that able to be provided by a local authority will already have been considered as part of the CHC process. Hence, as long as the process is followed correctly, by the time the CCG has got to the point of deciding that a patient does not qualify for CHC, the overall level of social care needed by the patient should not be beyond that which a local authority is entitled to provide. The range of social care and personal support services to be provided by the local authority will be determined by the local authority applying their own policies. This may well not meet all the social and personal care needs of the patient but that decision does not impose any duty on the CCG to plug the gaps.

13.4 There may, of course, be elements in the overall care package which comes out of the care planning process which need to be provided by a doctor or nurse or other NHS specialist. Those elements, if they are to be provided (and the CCG does not of course need to meet every healthcare need), will have to be provided by CCG staff or otherwise funded by the CCG. The core accommodation and social care costs however should not be met by the CCG.

14 **Cost sharing arrangements with local authorities outside CHC.**

14.1 There is a widespread practice of dividing up the costs of meeting services for patients outside hospital who have significant health needs but do not qualify for CHC between the NHS and local authorities, often on a 50/50 basis. These arrangements result in NHS funds

being used to meet part of the costs of accommodation and social care services for non-CHC patients. There is no legal basis for making such payments.

14.2 The National Framework Guidance states at paragraph 108:

“It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS continuing healthcare, and for the healthcare part of a joint care package”

14.3 That Guidance accurately identifies that, where a patient is not eligible for CHC, CCGs should only fund the “healthcare part of a joint care package”. That means the cost of services of those healthcare professionals who are needed to provide support to a community based patient. This duty is made clearer at paragraph 114 which provides:

“There will be some individuals who, although they are not entitled to NHS continuing healthcare (because ‘taken as a whole’ their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool that are not of a nature that an LA can solely meet or are beyond the powers of an LA to solely meet. CCGs should work in partnership with their LA colleagues to agree their respective responsibilities in a joint package of care, including which party will take the lead commissioning role”

14.4 However the duty to fund services to meet “specific needs” will not generally (if ever) extend to a duty to contribute to the costs of accommodation or social care services for the patient. Outside CHC arrangements it would generally be beyond the powers of the CCG²⁵ to expend monies to support social and personal care services because they are likely to be outside the range of services that the CCG has a statutory power to deliver under section 3 of the National Health Service Act 2006.

14.5 The scope and limits on the duties of the NHS to provide accommodation as part of its overall responsibilities are not always fully understood. The correct position was set out by HHJ

²⁵ The CCG’s powers are limited by statute and it would be ultra vires for the CCG to act beyond these powers.

Hickinbottom (now Hickinbottom LJ) in *Secretary of State for Work and Pensions v Vale and others* (CDLA/3161/2003 dated 27 July 2005) where the Judge said:

“Perhaps because it appears not to be mentioned in circulars issued by the Department of Health, it seems often to be overlooked that, where a person requires accommodation because of his or her need for nursing services (rather than because of a need for “care and attention” to which any nursing services required are merely incidental or ancillary), it is the duty of the National Health Service to make such accommodation available under section 3 of the 1977 Act, either directly or by making arrangements under section 23 to place a person in a nursing home. That is because the implication of *Coughlan*, *White* and *Botchett* is that the accommodation that is required in those circumstances falls within the scope of section 3(1)(a) or (b) of the 1977 Act. A local authority has no power to provide such accommodation due to the effect of section 21(8) of the 1948 Act. Of course, a person who is entitled to services may choose not to take advantage of the National Health Service and instead to pay for his accommodation and nursing from his own resources or with help from a relative or friend. However, that must be a matter of choice, exercised by someone competent to make the relevant decision.

This is probably still good law despite the Court of Appeal’s decision in *Whapples* (see paragraph 3.2 above) but legal advice should be sought if needed.

14.6 Thus if the CCG enters into a 50/50 cost sharing arrangement for a patient who does not qualify for CHC, the CCG may well be contributing to the cost of the patient’s accommodation in circumstances where the CCG has not power to meet any part of the patient’s accommodation costs. The better approach is for the CCG to work out the (approximate) cost of the healthcare inputs into the package which the CCG is prepared to fund, and then to make a contribution to the overall package which is consistent with the level of its commitment. If there are disputes about the right division of costs between the local authority and the CCG this can be resolved using the dispute resolution process set out above.

15 **Review of CHC eligibility decisions.**

15.1 When a decision is made that a patient is eligible for CHC, the panel should fix a date for reviewing that decision. The initial review should be after 3 months and then the review should happen at least annually. However if a patient's medical condition is expected to change (for the better or worse) within the year a review after less than a year may well be appropriate.

16 Special categories of patients

16.1 There are some categories of patients whose special needs stand apart from the CHC process or who require special consideration. These include:

- a) Children;
- b) Palliative or near death care for patients who are in a terminal phase of life;
- c) Patients with learning difficulties;
- d) Former long stay patients;
- e) Patients where there are section 28A agreements; and
- f) Patients leaving in-patient mental health care under section 117 of the Mental Health Act 1983.

16.2 **Children:** The National Framework for CHC only applies to adults. The National Framework for Children and Young People's Continuing Care²⁶ provides a framework for making decisions relating to children. The scheme is somewhat different to CHC for adults for a variety of reasons including the need for educational input for the child, the impact of special educational needs and the fact that the child will almost certainly be a "child in need" under section 17 of the Children Act 1989 and thus the duties on the local authority will be different to the local authority's duties to an adult who needs services under the Care Act 2014. Hence no assumption can be made that the legal framework set out above applies in the case of children.

16.3 **Palliative or near death care for patients who are in a terminal phase of life:** CHC has always been awarded on a more generous basis to patients who are in the final few months

or weeks of their lives. Whilst the principles set out above continue to apply to those in a terminal phase, CCGs are expected to work swiftly to resolve applications where there is clear evidence that patients are in a terminal phase of life and to flexible about the nature of the package to be offered to such patients.

- 16.4 **Patients with learning disabilities:** There are no special rules for patients with learning disabilities in relation to CHC, although the inclusion of “challenging behaviour” as one of the domains in the Decision Support Tool which can lead to a “priority need” can often lead to such patients being treated in a separate way to other groups of patients.
- 16.5 The recognition that the vast majority of learning difficulty patients have a primary need for social care support rather than having a primary healthcare need has led to the transfer of responsibility for this group of patients from the NHS to community care over the last 30 years. However, there remain large numbers of learning disabled patients who continue to be funded by the NHS solely because they are assessed as having a high level of challenging behaviour. The Decision Support Tool indicates that patients with the highest level of challenging behaviour can qualify for CHC on this ground alone, provided the level of severity is at the very highest end of the spectrum. However even with such patients, the test under the 2012 Regulations is whether the highest level of challenging behaviour gives rise to a primary health need. If the challenging behaviour gives rise to hugely complex social care management without the direct input on a regular basis of healthcare professionals, the primary health need test is unlikely to be satisfied even if the Decision Support Tool points towards CHC eligibility.
- 16.6 Whilst cases are, of course, fact specific, a number of CCGs have undertaken review processes of patients who have been awarded CHC on the basis of challenging behaviour alone in order to determine whether this genuinely leads to a primary health need.
- 16.7 **Former long stay patients:** There are a limited group of former residents of long stay mental hospitals where the NHS has been provided with dowry funding to support the patient for the rest of their lives. If a patient falls into this category then, if they do not qualify for CHC under

²⁶ See <https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national->

the National Framework and are being supported by local authority provided social care, the money provided under the dowry should be passported through to the local authority under “section 28A” agreements – now agreements under section 256 of the National Health Service Act 2006. However these are payments by CCGs to support the discharge by local authority social services departments of social services functions – i.e. the provision of community care services by social services authorities and not services for which the CCG has statutory responsibility.

16.8 Otherwise there are no special rules for former long stay patients. Over the years this group of patients have been supported by the NHS, by the benefits system and are now, where appropriate, supported by local authorities. Large sums of government funding have been passed from one department to another as responsibility has moved. The fact that a patient, who does not have a dowry payment, was once supported in an NHS facility does not create a responsibility on the NHS to meet the costs of that patient for the rest of his or her life. However there may well be circumstances where the NHS chooses to provide some support for such patients even though under no legal obligation to do so. The details of such support are outside the scope of this chapter.

16.9 **Patients where there are section 28A/section 256 agreements:** There are some patients or groups of patients where the NHS has entered into long term agreements to meet or support the social care costs for those patients. This needs to be carefully distinguished from CHC. These agreements – formerly known as Section 28A agreements (now agreements under section 256 of the National Health Service Act 2006) are for a CCG to meet the costs of helping local authorities deliver on the duties owed by local authorities to patients or service users. They are designed to be used where the CCG is satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of health services delivered under section 3 (1) of the 2006 Act. It is possible for a patient who does not qualify for CHC to be able to benefit from a section 28A agreement.

16.10 However, there are few if any circumstances where a CCG is legally obliged to enter into this type of agreement to support the local authority. The CCG has a statutory discretion and

“may” enter into such agreements but is not obliged to do so. Any such agreements are legal documents which can place binding obligations on the CCG. Such agreements need to be drawn up very carefully and signed off at Director level. Staff who feel that such an agreement may assist in an individual case are invited to seek specific advice from within the CCG.

16.11 Patients leaving mental health care – section 117 of the Mental Health Act 1983: Patients who are leaving detention under the Mental Health Act 1983 have a separate legal right under section 117 of the 1983 Act to after care services. This is entirely separate from the CHC system and is a legal duty owed to such patients jointly by a CCG and the relevant local authority. Such patients are entitled to support for their mental health needs from both the CCG and the local authority without the need to be assessed under the CHC regime. The division of responsibility between health and social services should be set out in a local agreement and this is a rare occasion on which CCGs can agree to meet 50% of the costs of a care package.

16.12 It is possible for patients to have both profound physical and mental health needs. In that case a patient would fall to be assessed for their physical needs under the CHC system and would be entitled to support under section 117. Aside from such unusual circumstances, patients being discharged from compulsory in-patient mental health should not be assessed for CHC.

17 Which CCG is the Responsible Commissioner for NHS Continuing Care?

17.1 There will be a separate chapter on identifying the Responsible Commissioner, including looking at the “Who Pays” Guidance²⁷. The rules are therefore only summarised here.

17.2 If a patient comes to a CCG to seek support, the first issue that the CCG is required to consider is whether the CCG has a statutory responsibility for that patient. Broadly the CCG provides services to:

²⁷ See <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>

- a) The patients of GP practices who are members of the CCG (whether the patient lives in that area or not)²⁸;
- b) Patients who do not have a GP but who are usually reside in in the area served by the CCG;
- c) The other persons who are listed in schedule 1 to the 2012 Regulations.

17.3 If a patient has been placed in the CCG's area to receive in-patient or continuing healthcare at any time after April 2006 (or April 2007 in the case of a child) by another CCG, the placing CCG retains funding responsibility for the patient²⁹. Equally, if the CCG have placed a patient elsewhere, we may retain responsibility. The Department of Health has provided detailed Guidance on the Responsible Commissioner. The "Who Pays" Guidance should be consulted if there are concerns about whether this CCG is responsible for funding a case.

17.4 There are particular problems with the "Who Pays" Guidance and the allocation of responsibilities between CCGs for patients who are formerly detained under section 3 of the Mental Health Act 1983, and are thus entitled to "after-care" services once they are released from detention. Allocation of responsibility between CCGs for such patients is primarily governed by the place of ordinary residence of the patient as opposed to the CCG which was responsible for funding the placement where the patient was detained. The Secretary of State has recently made new Regulations, Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2016, which were supposed to have ensured that the same CCG is responsible for funding a placement and for funding section 117 aftercare. However there are technical problems with the Regulations and they may well not have achieved this intended effect.

²⁸ See section 3(1A) of the NHS Act.

²⁹ See paragraph 3 of Schedule 1 to the 2012 Regulations.